

Original articles

Physician attitudes and behaviour regarding erectile dysfunction in at-risk patients from a rural community

Eric Perttula

Summary

Erectile dysfunction affects many men in the United States. A 34% prevalence is estimated among male family practice patients. It is associated with a loss of self-image, self-confidence, and even chronic anger. Several risk factors increase the risk of erectile dysfunction. Prevalence is increased by 20–40% in patients with diabetes, hypertension, and those over 65 years old. While erectile dysfunction is generally acknowledged as an important health problem, misconceptions remain as to the need for clinician-initiated discussion regarding the issue. A retrospective chart review of patients at three health clinics in a predominately rural area was conducted. Subjects ($n=102$) were those at risk of erectile dysfunction who had undergone a complete physical exam between October 1995 and December 1996. All physician encounters were examined for documentation of physician inquiry about erectile dysfunction. A survey of physician perceptions on initiating discussions of erectile dysfunction was also conducted. Physician-initiated discussion of erectile dysfunction was documented in 17% of patients with hypertension, 18% with diabetes mellitus, and 30% of patients > 65 years. The physician survey (11 respondents) showed 27% reported asking all male patients about erectile dysfunction at routine physical, while 45% reported asking 80% of their male patients. A 'lack of time' or belief that the 'patient will initiate discussions' was cited by several practitioners as reasons why inquiries were not initiated. All physicians in the study agreed that sexual function is an integral part of overall health. They either overestimated the percentage of patients asked about erectile dysfunction or they had not documented results consistently.

Keywords: erectile dysfunction; physician attitudes

problem involves cultural and religious issues and has implications for personal health, interpersonal relationships, and public health. The inability to attain and maintain an erection leads to stress and tension in relationships between men and their partners. Depression is common, as well as feelings of failure, devastation, and humiliation.³ This in turn leads to loss of self-image and self-confidence. Anger may develop. These feelings of sadness, depression, and anger affect the way the person with erectile dysfunction interacts within his sexual relationships. If the dysfunction is severe enough, the individual may avoid intimate relationships altogether, for fear of not being able to perform sexually.

The National Institutes of Health Consensus Development Conference on Impotence (1992) concluded that erectile dysfunction is an important public health problem.⁴ It is also costly to the healthcare system. Nationally, erectile dysfunction accounted for 400 000 office visits and 30 000 hospital admissions in 1985. Direct costs were estimated at \$146 million.⁵

Common risk factors for erectile dysfunction include age, diabetes, and use of antihypertensive agents. The prevalence increases with increasing age. Approximately 8% of men have erectile dysfunction at age 55 years, 40% of men over 60 years of age, and up to 75% of men aged 80 years.⁶ Erectile dysfunction is more common in men with diabetes than in the general population and occurs at younger ages.⁷ Antihypertensive drugs, including beta-blockers, calcium channel blockers, and thiazide diuretics have been shown to be associated with erectile dysfunction. One study documented a 25% incidence of drug-related erectile dysfunction among male medical clinic out-patients.⁸

While erectile dysfunction is generally acknowledged as an important health problem, there are still some common misperceptions regarding this issue. Many older patients assume that all age-related loss in erectile function is 'normal'. Still others believe that there is no cure for their erectile problems. Because of the very personal and private nature of the subject, many patients are reluctant to initiate discussions on erectile dysfunction with their personal physician. Health professionals therefore need to be prepared to open discussions in this area. In one study, the majority of male patients queried (85%) believed that sexual

Michigan State University/College of Human Medicine (Flint Area Medical Education) and Hurley Medical Center, Flint, Michigan, USA
E Perttula

Correspondence to
Kimberly R Barber, Hurley Medical Center, Research Department 8W, One Hurley Plaza, Flint, Michigan 48503, USA

Accepted 4 August 1998

Erectile dysfunction affects many men in the US; a 34% prevalence has been reported among male family practice patients.¹ Estimates range from 30 million males afflicted with minimal dysfunction to 10–20 million males with severe erectile dysfunction.² The

dysfunction was a subject that physicians should inquire about, while 74% reported that they felt 'under-satisfied' regarding physician inquiry into sexual matters.⁹ The same study documented that only 23% of men reported physicians had inquired about erectile dysfunction at all.

Methods

The purpose of our study was to evaluate how often patients in our community were being asked about sexual dysfunction. We specifically examined how often it was documented in the medical records that patients had been asked about erectile dysfunction. The study consisted of a retrospective chart review of patients at three out-patient healthcare clinics in a predominately rural area in Michigan. The two counties involved in the study are federally designated Health Professional Shortage Areas and are also designated Medically Underserved. The area has more families below the poverty level (22.2% *vs* 16.5%) than state residents in general. They also have fewer families in the higher income levels of \$50 000–\$99 999 (10.5% *vs* 26.8%). The largest employers are state and local government, the local hospital, and wood-related industries. The study area is more culturally homogenous than the state as a whole. Whites comprise 96.3% of the population, Blacks 2.2% (compared to 14% statewide), and Hispanics 0.6% (compared to 2.2% statewide). The area also has a higher percentage of elderly citizens than Michigan in general. In one county, approximately 530 adults have been diagnosed with diabetes and an estimated additional 280–530 adults may have undiagnosed diabetes. The second county has approximately 1200 adults with diagnosed diabetes and an estimated 470–1200 additional adults undiagnosed.

A chart review was conducted of all eligible patients (patients who had either a diagnosis of diabetes or hypertension, or who were age 65 or older and had undergone a complete medical history and physical examination) seen at each clinic from 1 October 1995 to 31 December 1996. Diagnostic codes were used to generate lists of patients with hypertension and patients with diabetes who had visited the clinics within the designated time frame. In addition, lists of patients who were 65 or older and had received a physical exam during that time were selected. This resulted in 102 eligible subjects.

Each chart was then examined for mention of sexual function or dysfunction, diagnosis of erectile dysfunction, master problem list with sexual dysfunction, or completed intake questionnaire with questions regarding sexual functioning. For each subject, all physician encounters (ie, physical exams, routine follow-ups, problem-specific visits) were examined for documentation of physician inquiry, for the 2-year period prior to the most recent visit.

A follow-up survey was distributed to each healthcare provider ($n=11$) in the study area. Providers were asked to estimate the percentage of their male patients with whom they dis-

cussed sexual functioning during the routine physical, diabetic exams, and hypertension checks. Providers were also queried as to why they did not question patients about erectile dysfunction in instances where no such discussions were initiated.

Results

A total of 260 male patients met one or more criteria for the study, 66 of whom were under 65 years, one had hypertension not linked to erectile dysfunction, and charts could not be located for 91. A total of 102 subjects were available for analysis, 34.3% with primary hypertension, 33.3% with primary diabetes, and 33.3% over 65 years of age. Several subjects had multiple risk factors: 27.5% were over 65 years and had hypertension; 13.7% were over 65 years and had diabetes; 6.9% had both hypertension and diabetes; and 8.8% had all three risk factors.

A small proportion of patients had documentation of discussions regarding sexual functioning. For the group as a whole, only 22% documented discussions of erectile dysfunction were found, comprising six (17%) of the 35 hypertensive patients, six (18%) of the 34 diabetics, and 10 (30%) of the 33 patients older than 65 years. For subjects with multiple risk factors, the number with documentation included seven (25%) of the 28 with hypertension and older age, two (15%) of the 14 with diabetes and older age, none of the seven with hypertension and diabetes, and one (11%) of the nine with all three risk factors.

Nine physicians and two nurse practitioners were asked about their role in inquiring about sexual function. One physician did not respond to all questions. Of the 11 responding, all believed that inquiring about sexual function for patients at risk was an integral part of the history and physical examination. Physicians were asked to estimate the proportion of examinations in which they ask about sexual functioning (figure 1). Some reported that they included the inquiry in all ($n=3$), or in a majority of the physicals they conduct ($n=5$). However, 73% of respondents reported making such an inquiry in only half or less of their diabetic examinations, and 64% reported making the inquiry in half or less of hypertension check-ups.

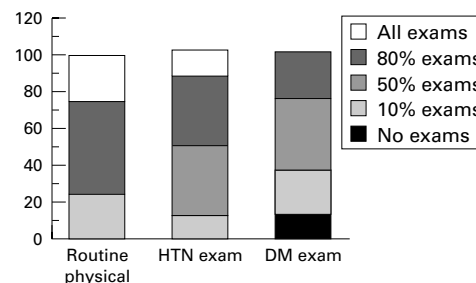


Figure 1 Physician-cited frequency of inquiry by type of examination (HTN, hypertension; DM, diabetes mellitus)

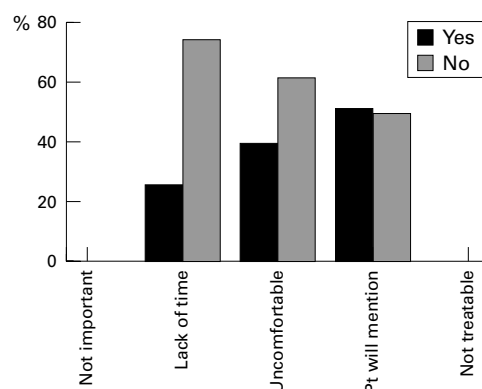


Figure 2 Reasons given by physicians for not initiating discussion of sexual dysfunction ($n=11$)

Reasons cited for not initiating discussions on sexual functioning (figure 2) included a lack of time ($n=3$) and patient/physician discomfort ($n=2$). The most common reason cited was a perception that the patient would initiate the topic of sexual dysfunction if he wanted to ($n=4$). Additional reasons given included a statement that the responses reflected past behaviour (suggesting a change of attitude), and the fact that the patient did not see the dysfunction as a problem. No one reported that the topic was unimportant or that the condition was not treatable.

Discussion

All 11 provider respondents in the study agreed that sexual functioning is an important component of overall health. These respondents inquired about erectile dysfunction in their diabetic male patients less often than in their hypertensive patients. This is in spite of data

showing that about 50% of male diabetics have some form of erectile dysfunction compared to 25% of men on antihypertensives. In addition, the majority of the male patients in our study had no documentation that they had been asked about erectile dysfunction. In a similar study of several urban practices, more than half (59%) the physicians surveyed reported never inquiring about erectile dysfunction; lack of time and lack of competence were given as the main reasons for this omission.⁶

Even though time issues are critical in many respects for the healthcare provider, lack of time did not appear to be the major factor in our study. Only 27% cited lack of time to explain why a discussion on erectile dysfunction had not been conducted. Over a third of respondents reported waiting until the patient initiated the discussion. However, studies examining male attitudes to erectile dysfunction have found that most male patients want physician-led discussions.⁹ Therefore, health professionals need to initiate discussions of sexual dysfunction with their male patients, especially those who are known to be at greater risk of erectile dysfunction, such as diabetics, those taking antihypertensives and those over 65 years old. While erectile dysfunction is a multi-faceted problem, there are many therapies available today which may allow men to lead normal sex lives. Accurate and thorough history taking is one of the most important tools at our disposal for elucidating and treating erectile dysfunction.

The author expresses appreciation to Kimberly Barber, MS (Hurley Medical Center) for her statistical expertise, writing assistance, and encouragement, and to Karen Chase, MD (Michigan State University) for her assistance in the implementation of the study. Funding for this research was provided by a grant from the Michigan State University Community/University Health Partnerships.

1 Schein M, Zyzanski SJ, Levine S, *et al.* The frequency of sexual problems among family practice patients. *Fam Pract Res J* 1988;7:122.

2 Benet AE, Melman A. The epidemiology of erectile dysfunction. *Urol Clin North Am* 1995;22:699-709.

3 Perring M, Moran J. Holistic approach to the management of erectile disorders in a male sexual health clinic. *Br J Clin Pract* 1995;49:140-44.

4 National Institutes of Health Consensus Development Conference Statement. 1992, December 7-9; 10(4):1-31.

5 National Center for Health Statistics. *Detailed diagnoses and procedures for patients discharged from short stay hospitals: US 1985*. Hyattsville, MD: US Dep Health and Human Services Publications No PHS-87-1751, 1987.

6 Morley JE. Impotence. *Am J Med* 1985;80:897.

7 Feldman HA, Goldstein I, Hatzichristou DG, *et al.* Impotence and its psychosocial correlates. Results of the Massachusetts Male Aging Study. *J Urol* 1994;151:54-61.

8 Slag MR, Morley JE, Elson MK, *et al.* Impotence in medical clinic outpatients. *JAMA* 1983;249:1736-40.

9 Metz ME, Seifert MH. Men's expectations of physicians in sexual health concerns. *J Sex Marital Ther* 1990;16:79-88.